Brattleboro Memorial Hospital
EXCEPTIONAL CARE FOR OUR COMMUNITY

FY2023 Budget Narrative

A. EXECUTIVE SUMMARY

Provide a summary of the hospital's FY23 budget submission, including any information the GMCB should know about programmatic changes, such as staffing, specific service lines, operational changes, any further impacts of COVID-19, and engagement in sustainability planning at the hospital. Specifically pertaining to sustainability planning, please describe how the hospital is preparing to engage in sustainability planning with the Green Mountain Care Board.

FY2022 and FY2023 is a tale of two distinct budget periods for Brattleboro Memorial Hospital (BMH) due to the effects of Covid19 on patient volumes and labor force. From October 2021 through December 2021, BMH had stabilized and exceeded the NPR/FPP reduced budget and the originally submitted budget. January 2022 Covid19 was again impacting BMH, this time our labor force which was already at compromised numbers. At the highest levels, up to 10% of our employees were not able to come to work as a result of Covid19 protocols. As a result services to patients had to be reduced.

This reduction along with the increase in contract labor at its exorbitant rates has created operating losses for the months of January 2022-May 2022.

From the volume perspective, BMH experienced decreased patient visits across all major departments and medical practices.

As we look towards FY2023, the use of screeners-although reduced-will remain.

Changes to Senior Leadership were many in FY2022. January 2022, Eilidh Pederson, COO left BMH to pursue opportunities closer to her home state of Minnesota, April 30, 2022 our long tenured President/CEO, Steven R Gordon retired and our new President/CEO, Christopher J Dougherty started on May 9, 2022, and on July 1, 2022 our CFO, Andre Bissonnette left to pursue opportunities at NVRH.

Following in the footsteps of the leadership team that has departed, the current leadership team at Brattleboro Memorial Hospital is dedicated to creating a sustainable future for the organization. We are poised and ready to partner with the Green Mountain Care Board and any other entitites in creating that sustainable future and transforming into the hub of hope, health and healing for our entire community.

For FY 2023, with unprecedented workforce shortages affecting rural hospitals with particular force, and inflation at a 40 year high, BMH remains committed to providing and preserving essential services that benefit the health and wellbeing of every person in our community. This current and very difficult operating environment only strengthens our resolve to embrace change and transformation in Vermont's healthcare delivery system as we work towards securing accessible, high-quality care at the lowest possible cost. Like other hospitals in our state, BMH needs a budget that offers reasonable

stability during tough times and allows us to continue moving forward as we work to meet the broader, more long range vision of transforming our healthcare delivery system.

B. YEAR-OVER-YEAR CHANGES

Explain each component of the budgeted FY23 based on the prompts below, please explain the hospital's budget-to-budget growth (or decline), budget-to-projection growth (or decline), including any ongoing COVID-19 assumptions.

i. NPR/FPP: Overview

a. Referencing the data submitted in Appendix 1 of Part B below, explain each component of the budgeted FY23 NPR/FPP change over the approved FY21 budget, referencing relevant FY22 budget-to-projection variances.

The change in NPR/FPP from FY2022 Budget to FY2023 Budget is 13.3%.

The Rate Effect makes up 66% of the increase in NPR/FPP from budget FY22 to budget FY23 with additional utilization accounting for 36% of the increase. There is also a payer mix shift in utilization from Medicare and Medicaid to Commercial which is part of the 36% increase.

The FY22 Projection to FY23 Budget has a small increase in utilization. The majority of the increase is from rate increase. This is a result of the first 3 months of FY22 volumes being over budget.

i. Discuss changes in NPR/FPP expected from Medicare, Medicaid, and Commercial; and other reimbursements from government payers.

There are no significant changes in NPR/FPP from Medicare, Medicaid. Commercial will see the greatest impact from the changes in NPR/FPP.

ii. Also include any significant changes to revenue assumptions from FY22 (e.g., Centers for Medicare and Medicaid Services (CMS) and Department of Vermont Health Access (DVHA) reimbursement policies, reimbursement adjustments, settlement adjustments, reclassifications, other accounting adjustments, rate changes, utilization, and/or changes in services).

1. ***Include an analysis, as required under 18 V.S.A. § 9456(b)(9), that reflects a reduction in net revenue needs from non-Medicaid payers equal to any anticipated increase in Medicaid, Medicare, or another public health care program reimbursements, and to any reduction in bad debt or charity care due to an increase in the number of insured individuals.***

BMH does not have any significant changes to revenue assumptions from FY22 for CMS or DVHA, reimbursement adjustments, settlement adjustments, reclassifications, other accounting adjustments, rate changes, or utilization of changes in services.

ii. NPR/FPP: Utilization

a. Describe any significant variances from the FY22 budget and projection (including changes in reimbursements and utilization).

Variances in utilization from the FY22 budget are in our inpatient areas, operating rooms and our chargeable supply areas, pharmacy and chargeable supplies. There is increased productivity with our orthopedic surgeon group which has increased our operating room volumes as well as the total joint implant volumes which are our chargeable supplies. Our oncology/infusion area has seen an increase in volumes which has a direct impact on our chargeable pharmaceutical supplies. Both pharmaceutical supply and chargeable supply revenues have a direct supply expense.

b. Referencing the data submitted in Appendix 3 of Part B below, explain changes in your utilization assumptions to support your NPR/FPP variances.

The utilization assumptions used in the development of the FY2023 budget were based on year to date January 2022 volumes annualized (projected). The volumes were evaluated and adjusted if needed to accommodate for any changes anticipated for FY23.

iii. Charge Request

a. Referencing the data submitted in Appendix 2 of Part B below, explain the hospital's overall charge request on the charge master in Table 1.

BMH's overall charge request is 14.9%. This is composed of a charge increase of 1% for outpatient practices, pharmacy and supplies and 20% on inpatient and outpatient hospital services.

b. Explain how the request impacts gross revenue, NPR and FPP by payer and what assumptions were used in quantifying the requested increase/decrease for each in Tables 2-3. Describe how the charge request affects the areas of service (for example, inpatient, outpatient, etc.) in gross revenues, NPR and FPP by payer. Explain the underlying assumptions and methodology used to make that allocation.

The charge increase is not specific to the payers, it is applied the same to all payers for gross revenues. The assumption of 1% charge increase for outpatient practices, pharmacy and supplies is that there has not been a charge increase in many years to the practices and many of the contracts are the lower of charge or fee schedule.

The majority of increase to NPR and FPP is allocated from the commercial payers. There is little additional NPR/FPP from Medicare or Medicaid with this charge increase.

c. Please indicate the dollar value of 1% NPR/FPP FY22 in Table 3 of Appendix 2 of Part B below, overall change in charge.

The estimated dollar value of a 1% fee increase equates to additional NPR of $645,113.

d. Please provide the following updates from the hospital's GMCB approved change-in-charge for FY22:

i. Did the hospital receive the full amount of its approved FY22 rate increase from the commercial payers?

Yes, the hospital received the full amount of its approved FY22 rate increase from the commercial payers with a couple of exceptions from out of state payers.

ii. Did the hospital increase its charges to the full approved amount for FY22, if not, why not and by how much did the hospital increase those rates?

Yes, BMH increased its charges to the full approved amount for FY22.

iii. How did the resulting increase impact areas of service (specifically, inpatient, outpatient, professional services, etc.).

The increases we made to fees and the reimbursement we received enabled us to continue to offer basic, essential health services to our community.

iv. Adjustments (physician transfers and accounting adjustments)

a. Account for operational or financial changes, including provider transfers and/or accounting changes.

There are no provider transfers or accounting changes for FY23. BMH did move to utilizing a budget system which is part of the accounting system for the FY23 budget process.

v. Other Operating and Non-Operating Revenue

a. Explain the budgeted FY23 other operating revenue and non-operating revenue changes over the approved FY22 budget, as well as relevant FY22 budget-to-projection variances.

Other operating revenue related to 340B has decreased $470k from FY22 budget. The pressures of Big Pharma has eroded revenues during FY22.

Non-operating revenue in made up of investment returns which have. BMH budgets this conservatively as the current market is volatile and unpredictable.

b. Please denote the COVID-19 advances, relief funds, and other grants received in Appendix 6 of Part B below, and the respective treatment of each funding source as of September 30, 2021, projected as of September 30, 2022, and budgeted as of September 30, 2023.

Description	Amounts Received Grand Total	Amounts Received	Recognized in Revenues	Recorded as a Liability	Amounts Received	Recognized in Revenues	Recorded as a Liability	Recognized in Revenues	Recorded as a Liability
		As of Sept. 30, 2021			As of Sept. 30, 2022			As of Sept. 30, 2023	
CARES Act Funding	$ 3,929,773				3,929,773	3,929,773			
Add Source of Funding	$ -								
Add Source of Funding	$ -								
Add Source of Funding	$ -								
Add Source of Funding	$ -								
Add Source of Funding	$ -								
Add Source of Funding	$ -								
Add Source of Funding	$ -								
Add Source of Funding	$ -								
Add Source of Funding	$ -								
Add Source of Funding	$ -								
Totals	$ 3,929,773.03	$ -	$ -	$ -	$ 3,929,773.03	$ 3,929,773.03	$ -	$ -	$ -

c. Please discuss to the best of the hospital's knowledge, any potential funds that could be received by the hospital (with an estimated timeframe) related to COVID-19 advances, relief funds, and other grants.

There is also a potential USDA grant that may become available which can be used for offsetting capital expenditures over the next 5 years and is structured as a matching grant of 35%. The total funding is currently unknown.

d. Explain the relative stability of significant sources of other operating revenue and non-operating revenue and discuss strategies to address revenue streams the hospital considers unpredictable or unstable

The 340B program has been identified as a risk since its inception. The program is currently stable and predictable with the exception of Big Pharma as noted above, but there are continued challenges to discontinue the program by the pharmaceutical companies. BMH continues to work through VAHHS and the American Hospital Association to lobby for this program as well as working through the federal congressional representatives of Vermont to support this program.

The Medicare Dependent Hospital status and Low Volume status are also at risk. These programs are currently in a 5 year renewal rotation and are due to expire September 30, 2022. BMH continues to work through VAHHS and the American Hospital Association to lobby for this program as well as working through the federal congressional representatives of Vermont to support this program.

vi. Operating Expenses

a. Explain changes in budgeted FY23 operating expenses over the approved FY22 budget.

The most significant change in the operating expenses from FY22 budget to FY23 budget is salary/benefit expenses and contract labor expenses due to the overarching national issues in the labor market. This expense increase accounts for 65% of the overall expense increase in the operating

budget. The other significant change which accounts for the majority of the remaining expense change is related to drug and chargeable supplies.

b. Describe any significant variances between your FY23 budget and FY22 projections (e.g., variances in costs of labor, supplies, utilization, capital projects) and how those variances affected the hospital's FY23 budget.

The most significant change in the operating expenses from FY22 projections to FY23 budget is salary/benefit expenses and contract labor expenses due to the overarching national issues in the labor market.

Medical/Surgical supplies have increased mainly due to increased volumes in our orthopedic joint replacement program.

Drug expense has increased as a result of increased cost of drugs mainly in the chemo treatment area and increased volumes of chemo patients.

c. Referencing the information and data submitted in Appendices 1 and 4 of Part B below and relevant portions of the FY23 budget submission, please discuss the categories of inflation and their relevance to the hospital's budget and operations.

With the wage and benefit budget accounting for 75% of the total expense budget, the most significant inflation category is wage and contract temp inflation. This accounts for the majority of the requested increase in NPR/FPP. The other significant inflation category is fuel.

d. Describe any cost saving initiatives proposed in FY23 and their impact on the budget.

As the new leadership team gets started, several cost reduction strategies will be pursued throughout FY23. Because the budget was already well on it way to be developed when the new team came on board, any savings are not reflected in the FY 23 budget proposal. These cost reduction strategies will be implemented throughout FY 23 and be incorporated into future:

- Reduce Physician and Advanced practice provider voluntary turnover.
- Reduce staff voluntary turnover (currently, at approximately 28%).
- Implement productivity benchmarks and goals for all staffing and create flex staffing protocols.

e. Describe the impact operating expenses have on requested NPR/FPP

Total operating expenses are increasing 12.0% which are offset by the increase of NPR/FPP of 13.3%.

vii. Operating Margin and Total Margin

a. Discuss the hospital's assumptions in establishing its FY23 operating and total margins. Explain how the hospital's FY23 margins affect its overall strategic plan. If the hospital relied on third party benchmarks or targets, please identify those benchmarks and sources (e.g., lending institutions, credit rating agencies, industry standards, parent company/affiliate policy). Please also discuss any relevant FY22 budget-to-projection variances.

BMH approached the FY23 budgeted operating margin by looking at the current year's volumes and expenses and adjusting accordingly for a full year of inflation. The year to date first four months of volumes FY22 were close to budget. The was a Covid19 impact on these volumes in March, April and May which affected along with increased expenses related to inflation and the labor market. The FY22 total margin includes non-operating income which is made up of investment returns. BMH takes a conservative approach for budgeting these returns and does not rely on them for operations.

The FY23 operating and total margins do not change the overall strategic plan.

b. Does the hospital's budget request include support or a need to support any other entities outside of the physical hospital? An example includes a higher operating margin to transfer surplus to a subsidiary.

No, the budget for BMH does not include support or a need to support any other entities outside of the physical hospital.

C. EQUITY

i. What is your hospital doing to recognize and correct inequities in your community, and prepare for the development of health equity measures?

RAND defines a health equity measurement approach as "an approach to illustrating or summarizing the extent to which the quality of health care provided by an organization contributes to reducing disparities in health and health care at the population level for those patients with greater social risk factor burden by improving the care and health of those patients."

- Establish a leadership role for Justice, Diversity and Inclusion
- Establish Oversite Group for implementation of Justice Equity Diversity and Inclusion workplan.
- Mandatory staff education regarding cultural diversity and competencies
- Develop focused interventions based on health inequities within our service area BIPOC community.
- Provide targeted outreach for services

D. WAIT TIMES

The Board staff and up to two Board members will establish a working group to include hospitals, Vermont Association of Hospitals and Health Systems, the Vermont Department of Financial Regulation, the Office of the Health Care Advocate, and other interested parties to determine by May 2, 2022, appropriate wait time metrics that hospitals shall submit as part of the FY23 budget process.

If the workgroup is unable to determine appropriate metrics, the hospitals shall report the following for each hospital owned practice (for each primary care and specialty care), as well as, the top five most frequent imaging procedures. Specifically, please report for each practice and imaging procedure:

i. Referral lag, the percentage of appointments scheduled within 2 days of referral.

Medical Group Referral Lag is 52% (75 of 145)

Radiology: Due to nuances of ordering/scheduling the 'Top 5' diagnostic imaging exams, it is not possible to accurately determine Referral and Visit lag. An example of the scheduling nuance is that that Orthopaedic x-rays (2 of the top 5) are not scheduled, but rather walk-in, coinciding with Orthopaedic clinic appointments. Therefore, BMH choses to use the 'third next available' metric for assessing wait times. See the chart below.

Modality (as of 6/28)	3rd Next Available Date	Notes
DEXA/Bone Density	7/5	DEXA is generally only performed 1-2 days/week.
CT	Same Day	CTs will always be accommodated same day.
Fluoroscopy	7/5, 7/6	Dates vary slightly due to exam type. This is also radiologist dependent and is influenced by staffing.
Diagnostic Mammo	6/30	Diagnostic exams are often as soon as next day or the following Monday or Thursday (whichever is earlier).
Screening Mammo	6/30	
MRI	7/2	
Nuclear Medicine	6/30	
Ultrasound (Medical)	7/1	Similar to CT and general X-Ray, ultrasound completes a significant number of close-in add-ons. These are largely discharges from the Emergency Departments and are scheduled same day.

ii. Visit lag, the percentage of new patients seen within 2 weeks, 1 month, 3 months, and 6 months of their scheduling date.

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Visit lag for the Medical Group is as follows:
2 weeks - 2%
1 month - 15%
3 months - 53%
6 months: - 28%

In each case, hospitals shall outline steps to resolve wait times.

BMH Medical group shares third next available information with clinicians and leadership; reviewing visit type usage to determine potential opportunities for template changes

BMH radiology reviews third next available data weekly and adjust operations as needed to maximize access.

E. RISKS AND OPPORTUNITIES

i. ***Please discuss the hospital's risks and opportunities in FY23. Recognizing the risks and opportunities in the current environment, please explain how the FY23 budget proposal supports strategies for addressing these issues.***

Major Risks for FY2023 are as follows:

- **COVID-19 Resurgence:** Our budget supports our response to a resurgence of Covid19 as we have developed a separate 7 bed Negative Pressure Unit within the Hospital, maintained several screener positions, and added hours to our Infection Prevention program. PPE Supplies continue to be acquired and stored.

- **Medicare Dependent Hospital (MDH)/Low Volume Designation:** These programs are scheduled to expire in September 2022; we continue to monitor and support efforts to permanently extend them.

- **340B Program:** This critical program continues to be under attack by Big Pharma. We have invested in staff designated to manage this program.

- **OneCare risk-based performance:** BMH continues to participate in OneCare's efforts to support hospitals in transitioning from fee-for-service to value-based reimbursement. (see **D** below)

- **Loss of Provider Based Billing:** The Supreme court ruled on June 29th, 2021 that off-campus ambulatory practices will no longer be able to participate in provider based billing. Currently, this impacts two of BMH's outpatient practices; Brattleboro Family Medicine and Putney Family Healthcare.

- **Limited patience with long-term population health investments which don't yield short term returns**
    - Healthworks RN (Homeless shelter and Respite bed)
    - Care Coordination
    - Dental Health
    - Embedded Behavioral Health Therapists in Primary Care Practices
    - Community Health Team and Hub and Spoke

Major Opportunities for FY2022:

- **Continued Revenue Cycle Improvements**

- **Regional Psychiatric Strategy Group (Retreat, BMH and HCRS)**
    - ACT (Assertive Community Treatment) Initiative

- **Continued collaboration with DH and Cheshire Med/ Evolution of Strategic Partnership**

- **LGBTQ+ and Racial Diversity Initiatives/DEI Coordinator**

- **Telemedicine**

ii. Please describe the impact of COVID-19 on access to care/wait times at your organization, including the use of telehealth and telemedicine, COVID-19 related safety protocols, and other relevant factors.

Emerging from COVID has had a favorable time on access to care and wait times at BMH. During the height of the Pandemic, we used the time to, on a parallel track, prepare ourselves for coming out of the Pandemic. The primary care clinicians rallied to find ways to allow more patients in need of primary care to receive services, without barrier and without delay. Clinicians wanted to be ready to accept existing patients who had delayed much needed routine care, and to be ready to accept new patients, who realized through the course of this virus, the importance of having a primary care clinician and having timely access to a medical home. Thus, we went from a 'third next available' new patient slot of 120 days to 75 days, as we currently stand, in four months' time.

Tele-medicine is now a routine part of ambulatory care. We envision that this mode of care will remain, so long as it is reimbursed in the same way that an in-person evaluation and management code is reimbursed and is recognized by CMS. Tele-medicine was the only way care could be delivered for so many months and it continues to be essential to home bound patients and those experiencing depression and anxiety. There is a cost to tele-medicine and we pay that on an annual basis. BMH uses Blue Stream and the implementation was over $25,000. The annual cost for BMH to host the platform is $12,000. Lastly, in order for clinicians to provide tele-medicine to their NH and MA patients (there are quite a few given the location of BMH), clinicians needs to be fully licensed in those States. There is an initial cost and an annual cost to this licensure.

As previously reported, BMH has stood up and has committed to maintaining a negative pressure unit for patients experiencing any respiratory symptoms, as an important safety and infection prevention model. Lastly, BMH has installed HEPA filters in a designated exam rooms in each of their primary care practices to allow for BMH to safely care for those who are COVID-19 positive and require care in an ambulatory setting.

iii. Please discuss any lessons learned from the COVID-19 pandemic thus far, and any positive changes the hospital has adopted or plans to adopt for the future.

The primary positive lesson learned, as we emerge from this pandemic, is the power of the VAHHS collaboration with the State of Vermont. Vermont's 14 Hospitals worked collaboratively in ways unforeseen, but essential and crucial to the well-being of Vermonters. In Brattleboro, BMH became the main source of testing and vaccinations for our community which performed over 20,000 vaccinations…not bad for a little hospital!

iv. Please discuss the workforce challenges of the hospital as it relates to the following:

a. **Vacancy rate by Primary Care MD, Specialty MD, RN, Nursing Support and All Other.**

b. **Provide your average turnover rates by Primary Care MD, Specialty MD, RN, Nursing Support and All Other for FY2018-FY2021.**

   We do not have the data for these time periods.

c. **Report on initiatives and funding sources to reduce workforce pressures through recruitment and retainment.**

   BMH has had a nursing residency program since 2019, which has been very successful. The number of nurse residents that will be at BMH at the start of FY23 is nine, which will help in filling some of the vacancies that we currently have, and some that we are anticipating through retirements for FY23.

d. Please comment on and quantify the impact of nursing and MD travelers on your budget request.

BMH currently has 16 fte nurse/allied health travelers and 0.5 fte MD travelers. BMH has budgeted to have these 16 fte travelers (nurse/allied health) for FY23, with no MD fte travelers expected/budgeted.

e. Provide salaries per FTE, FTEs per adjusted occupied bed, and salaries expense to NPR

a. Salary per FTE= $86,334 (Wages $47,544,361 / FTE 550.7)
b. Salaries expense to NPR=45.1% (Wages $47,544,361 / NPR $105,484,860)

F. VALUE-BASED CARE PARTICIPATION

i. ***Referencing the data submitted in Appendix 5. if there are any value-based care programs that the hospital is not participating in for CY 2023, please explain why and describe any barriers that exist. What changes, if any, to each of these programs would need to be made in order to facilitate your participation?***

BMH is participating in all of the programs, Medicare, Medicaid, Blue Cross and MVP.

Assuming participation in one or more value-based care program(s) through OCV:

ii. **Understanding that the pandemic has just started to recede, what changes in each of the hospital's cost centers that relate to value-based care initiatives (e.g. population health management, care coordination, chronic condition management, etc.) have been made as a result of participating in the ACO? Be specific in describing each cost center and how it has changed since joining the ACO. Additionally, speak to how the fixed payments or other ACO payments from OCV are or are not advancing value-based care at your hospital.**

iv. A. As the pandemic recedes, what specific population health priorities are emerging for the hospital?

Mental Health Interventions

- Increase depression screening in Primary Care/OBGYN/ED through screening, brief intervention, navigation to service model (SBINS)

- Explore utilizing licensed clinical social workers in primary care to support team based care for psychosocial needs.
- Increase employee literacy in Trauma Responsive Care and integrate trauma responsive care
- Increase number of care plans for people who have high utilization in the ER through the use of imbedded Psychiatric APN in ER.
- Continue pilot of an embedded Psychologist within a specific Family Practice setting

Chronic Care Interventions

- Pilot Diabetes prevention self-management program
- Reinvigorate medication take back program
- Initiate Healthworks aggressive community therapy program
- Pilot alcohol use disorder ambulatory medication management program

Cancer Interventions

- Increase colorectal screening rates
- Increase mammogram and cervical cancer screening rates
- Explore risk ranking for breast cancer

Healthy Aging Interventions

- Pilot Primary RN wellness visits

B. How will each of these priorities be conveyed to providers to in order to impact care delivery?

Every implementation will be discussed through Medical Staff committees and presented to the entire medical staff.

C. How will success be measured for each of these initiatives?

Every initiative will have targets established and will be monitored to insure we achieve target.

iv. **As of CY2022, OCV is providing each HSA with quarterly quality reports. How are the results of these reports being communicated to providers in a way that will impact care delivery and quality outcomes?**

These reports have been reviewed at the BMH OCV clinical steering committee meetings, which includes BMH medical staff representation. This group reviews quality data and identifies areas of opportunity. Once these areas are identified, BMH utilizes reports generated from the electronic health record to obtain data for all impaneled patients at the clinician level. This information is shared with clinicians during a meeting twice a year with their administrative and medical director.

v. A. **Regarding the CY2020 settlement information for the hospital (Separate tables will be provided by GMCB), what are the planned investments of those dollars in furthering the hospital's health care**

reform goals? If no investments in health care reform were made with these dollars, how were they invested?

B. **If the hospital experienced a net shared loss during this time period, how is the hospital using that information to inform change to the delivery system?**

E. CAPITAL INVESTMENT CYCLE

i. In accordance with 18 V.S.A. § 9435(f), describe the investment cycle and how it relates to the hospital's overall strategic plan. Discuss how the hospital's capital investment cycle has changed as a result of COVID-19. Please mention certain items and the resulting status as a result of COVID-19 (i.e. cancelled, postponed, rescheduled, etc.)

Each year BMH develops capital investment needs for new and replacement expenditures. Criteria used in prioritizing these expenditures include safety, quality of care, infrastructure improvements or replacement, environment of care, technology needs and regulatory requirements.

As a result of Covid-19, capital expenses and projects have been delayed, but the overall investment cycle has not changed. The only CON (Certificate of Need) project in process, which has been in process for the last 4 years, had a scheduled start date of April of 2020. Covid-19 had delayed the start of this project to September 2020.

ii. If any of the hospital's anticipated capital investments are required improvements (e.g., regulatory or accreditation requirements), please identify and explain

There are no anticipated capital investments that are required improvements for BMH.

SUPPLEMENTAL DATA MONITORING

i. Market Share Report. This will be a snapshot which will show the change in market share for "key service lines" over the past 5 fiscal years as reported by the state's hospital discharge database, VUHDDS. Market share will be defined as the percentage of service line charges from local residents (within a hospital's service area) versus non-local residents (outside a hospital's service area). Market share will be disaggregated by primary payer. See Patient Origin dashboard/"Patient Origin by Hospital" tab for an example.

a. Does this report reflect material changes in your NPR actuals over this time period?

This report appears to reflect the material changes in NPR, specifically during FY20 Q3 and FY20 Q4.

b. If not, how does the market share report distort or omit components of NPR?

N/A

ii. Reimbursement Analysis. This will outline patterns in the cost to deliver care for Vermont residents as reported to the state's all-payer claims database, VHCURES. Cost will be assigned at a claim level as specified in Medicare's cost reporting. Service lines will be reported by Medicare Diagnosis Related Group for inpatient services and by Ambulatory Payment Classifications for outpatient services. Note that only services with Medicare costs associated with them will be included in the report. (See links 1 and 2 for details about the methodology.) All results will be summarized in hospital-specific comparison tables broken down by primary payer group (Medicare, Medicaid, commercial). In addition, the report will highlight providers with exceptionally low or high costs, reimbursements, and/or proportion of costs covered.

a. For any service lines in which your hospital is highlighted, comment on any observations about this service line and how it may be reimbursed differently from other service lines you provide.

Without further analysis we have no comment.

b. Are there any errors in the data as shown? Cite your own data where possible.

Without further analysis we have no comment.

iii. Demographic Report. This report will summarize demographic data from the 2020 Census. Particular attention will be paid to CDC/ATSDR Social Vulnerability Index measures that relate to age and socioeconomic disadvantage.

a. How does the current makeup of your service area affect your budget assumptions?

Without further analysis we have no comment.

b. Does the makeup of other service areas affect your budget assumptions? Explain.

Without further analysis we have no comment.